Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Jim Ellis Atlanta, Inc. – **PPO High Medical Plan**

Coverage Period: **January 01, 2027 - December 31, 2027**
Coverage for: Individual, Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.novahealthcare.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-206-1040 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual / **$5,000** family for In-Network providers **$10,000** individual / **$20,000** family for Out-of-Network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered at no charge before you meet your deductible. Emergency room care and in-network office visits, urgent care, outpatient mental health services, rehabilitation services, habilitation services, and prescription drugs are covered after a copay before you meet your deductible. In-network diagnostic tests are covered at 20% coinsurance before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$7,500** individual / **$15,000** family for In-Network providers **$20,000** individual / **$40,000** family for Out-of-Network providers	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Pre-Certification penalties and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See CIGNA Provider Directory or call **1-855-206-1040** for a list of participating providers.	This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral.**
Is Pre-Certification required for services?	Yes, for certain services.	Failure to obtain precertification will result in a 100% penalty.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	Subject to deductible, then 40% coinsurance	None
	Specialist visit	$75 copay	Subject to deductible, then 40% coinsurance	None
	Preventive care/screening/immunization	No charge	Subject to deductible, then 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (no deductible)	Subject to deductible, then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.oneveracity.com/rxmembers	Generic Drugs/ Tier 1	SmartChoice Network: $5 copay (30-day), $7.50 (60-day), $10 (90-day); StandardChoice Network: $25 copay (30-day only)	Not covered	Must use a participating pharmacy. Retail: 30-day supply; 60-day and 90-day supply at SmartChoice Network pharmacies only. Prior Authorization may be required for certain medications. For verification call 1-888-388-8228. If you don't participate in the Personal Importation Program for an eligible drug, you'll pay 50% of the medication cost after two courtesy fills.
	Preferred Brand Drugs/Tier 2	SmartChoice Network: $25 copay (30-day), $37.50 (60-day), $50 (90-day); StandardChoice Network: $45 copay (30-day only)	Not covered	
	Non-Preferred Brand Drugs/ Tier 3	SmartChoice Network: $50 copay (30-day), $75 (60-day), $100 (90-day); StandardChoice Network: $70 copay (30-day only)	Not covered	
	Specialty drugs	Not covered	Not covered	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required
	Physician/surgeon fees	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted
	Emergency medical transportation	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance	Covered for emergencies only. Air ambulance is covered only when no other method of transportation is appropriate.
	Urgent care	$50 copay	Subject to deductible, then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization is required
	Physician/surgeon fees	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	Subject to deductible, then 40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network providers Provider	Out-of-Network Provider	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization Required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network providers Provider	Out-of-Network Provider	
If you are pregnant	Office visits	$75 copay	Subject to deductible, then 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Childbirth/delivery facility services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Pre-certification is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay in order to avoid a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network providers Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	50 visits per calendar year; Prior Authorization required.
	Rehabilitation services	$50 copay; $25 copay for mental health or substance use disorder services	Subject to deductible, then 40% coinsurance	20 visits per calendar year; visit limits apply per service/therapy, not combined across all rehabilitative services. Services to treat a mental health or substance use disorder, including autism spectrum disorder, have no visit limit.
	Habilitation services	$50 copay; $25 copay for mental health or substance use disorder services	Subject to deductible, then 40% coinsurance	20 visits per calendar year; visit limits apply per service/therapy, not combined across all habilitative services. Services to treat a mental health or substance use disorder, including autism spectrum disorder, have no visit limit.
	Skilled nursing care	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	160 visits per calendar year; Prior Authorization required
	Durable medical equipment			None
	Hospice services			None
If your child needs dental or eye care	Children's eye exam or glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bariatric surgery • Dental Care • Infertility Treatment • Long Term Care	• Non-emergency care when traveling outside the U.S. • Routine Eye Care • Routine Foot Care • Weight Loss Programs	• Injectable medications for the treatment of hemophilia, spina bifida, and cystic fibrosis, unless administered in an inpatient setting.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Chiropractic Care (limited to: 20 visits per calendar year)	• Hearing Aids (limited to: 1 per ear every 3 years; $3,000 max)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-855-206-1040. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. "Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner." A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-206-1040

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-206-1040

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-206-1040

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible $2,500**
- **Specialist *[cost sharing]* $75 copay**
- **Hospital (facility) *[cost sharing]* 20% coinsurance**
- **Other *[cost sharing]* 20% coinsurance**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible $2,500**
- **Specialist *[cost sharing]* $75 copay**
- **Hospital (facility)*[cost sharing]* 20% coinsurance**
- **Other *[cost sharing]* 20% coinsurance**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$70
Copayments	$1,200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,310**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible $2,500**
- **Specialist *[cost sharing]* $75 copay**
- ***H*ospital ER *[cost sharing]* $500 copay**
- **Other *[cost sharing]* 20% coinsurance**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,020**